COVERAGE, PREVENTION, REFORM (CPR):
Reviving Our Nation's Health Care System

Catastrophic health care costs often devastate families' income security and have a crippling effect on the U.S. economy. For example, medical costs play a role in as many as 46% of all personal bankruptcies**.** This, coupled with the 45 million uninsured individuals in the U.S., is a driver of rapidly increasing federal spending - a rate of health care spending that continually outpaces growth in wages and inflation.

In addition, the American health care system pays for care like a factory assembly line, rewarding quantity over quality. Perversely, Medicare often pays more for poor quality care than for high quality care, breeding a culture of medicine in which more care is better, when in fact the opposite is often true and when given all the information, patients often choose less costly options for the same quality of care.

For many across the United States, the health care system is flat lining and is in grave need of CPR: Coverage, Prevention, Reform.

By expanding affordable **COVERAGE** to all Americans, focusing on **PREVENTION**, and addressing broader health system **REFORM**, this proposal:

- Prevents personal economic collapse due to catastrophic health care costs;
- Ensures better access to provider networks and more timely care;
- Reduces the price of health care for consumers through access to negotiated rates;
- Limits the cost of uncompensated care for over-burdened health care providers;
- Transitions to a payment system based on quality, and enhances and integrates the delivery of health care; and
- Reduces the overall costs of health care.

COVERAGE: Affordable health coverage for all Americans

All Americans should have access to affordable, ***meaningful*** health care coverage and no American should lose their life-savings or their home because of illness or injury. The centerpiece of this proposal is to give every American access to an affordable, low-premium major medical private-market health insurance plan that insurers will be required to offer in every state-regulated health insurance market. The proposal:

- Defines a cost structure (not a benefit structure) in order to allow for flexible plan design;
- Expressly allows ***preventive benefits*** and ***disease management*** under the deductible with nominal co-payments for related office visits;
- Does not include an annual or lifetime cap on expenses above the deductible.

ENSURING ACCESS FOR ALL AMERICANS: In order to ensure that every American has quality, affordable coverage, the proposal requires proof of health insurance for every American over age 18 and requires insurers to offer coverage to all applicants, regardless of health status.

TARGETED SUBSIDIES FOR THOSE MOST IN NEED: The proposal includes direct subsidies for low-income individuals for the purchase of a low-premium major medical health insurance plan – subsidies for both the premium and deductible on a sliding scale up to 300% of the Federal Poverty Level (FPL).

MAXIMIZING STATE FLEXIBILITY AND INDIVIDUAL CHOICES: The proposal directs states to create points of entry for low-income families and individuals to enroll in a health insurance plan and access applicable subsidies. Mechanism design and functions of the point of entry (state-based insurance exchange, regulator, etc.) would be left up to the states. States would also be required to offer additional upgrade packages to be purchased on top of the low-premium major medical health insurance plan for those looking for additional benefits.

CAP TAX EXCLUSION FOR EMPLOYER-SPONSORED HEALTH INSURANCE: The proposal limits the extent to which employer-paid health insurance premiums and health spending from FSAs and HSAs are excluded from taxation. It includes in employees' taxable income any contribution that employers and employees made for health care costs that together exceeds $11,500 a year for family coverage or $5,000 a year for individual coverage (based on President Bush's Bi-Partisan Tax Advisory Panel recommendation).

TAX DEDUCTION FOR HEALTH INSURANCE PURCHASED IN THE INDIVIDUAL MARKET: The proposal provides a deduction for the cost of premiums for health insurance purchased in the individual market. The proposal applies the same premium caps applied to the tax exclusion ($11,500/family, $5,000/individual), but restricts the amount of the deduction to the amount of the health insurance premium below the cap.

PREVENTION: Focus on keeping Americans healthy

COVERAGE: The proposal provides first dollar coverage for ***preventive benefits*** and ***disease management*** with nominal co-payments for related office visits.

INCENTIVES: To provide employers with the opportunity to further develop incentive-based wellness programs, the proposal modifies the Health Insurance Portability and Accessibility Act (HIPPA) to allow rewards for wellness programs to exceed 20 % of the cost of employee-only coverage under a group health plan. By expanding HIPAA's wellness program reward provisions, employers will be afforded further flexibility as they design wellness programs to improve the health of their employees. Advanced incentives for health insurance premium and copayment rewards will motivate employees to take advantage of wellness programs that successfully make improvements to their own, and their family's overall health.

REFORM: Improving quality and efficiency while reducing costs

READMISSIONS AND PAYMENT INTEGRATION: Medicare's fee-for-service (FFS) payment system fragments care and does not do enough to encourage all of the beneficiary's providers to work together across an episode of care, from when the patient first gets sick or injured until they are recovered or discharged. This lack of coordination for a hospitalized patient is often marked by inconsistent attention throughout their hospitalization, at discharge or over the following weeks. According to MedPAC, 18% of Medicare hospital admissions result in readmissions within 30 days, costing $15 billion dollars – with nearly $12 billion of those estimated to be potentially preventable expenditures. The proposal includes:

- **Reporting.** Confidential and public reporting on healthcare acquired conditions (HAC) like medical errors, accidents or hospital acquired infections, focusing on a group of potentially preventable HACs and readmissions;
- **Payment.** Payment incentives to encourage hospitals to reduce HACs and readmission rates for potentially preventable conditions;

Ultimately, this would be expanded to create a program to integrate care by making a single payment for an entire episode of care from hospitalization through the month after discharge.

MEDICARE QUALITY ENHANCEMENT ACT: A key to improving health care quality is to provide the public with information to make informed health care decisions. This proposal would require the analysis of health care data for quality and efficiency with the results disseminated to payers, beneficiaries and the public. This proposal includes:

- **Reporting**. Beginning with confidential sharing of information with providers on their relative performance followed by public disclosure of this information in an easy to understand manner.

Ultimately, this information would be used to tier Medicare copayments and deductibles to encourage beneficiaries to utilize higher quality more efficient providers.

I**NCENTIVIZE SHARED DECISION-MAKING SAVINGS:** Shared decision-making (SDM) is utilized in conditions where there are multiple treatment and diagnostic options with a similar level of effectiveness. It works by providing the patient with information about all of their health care options and counseling to assist the patient to make the best treatment decision for them based on their health, their preferences and their beliefs.

- The program would start with grants to those who implemented the SDM system early on who would share their expertise with other providers. This program would serve to develop, train and test widespread implementation models for SDM in different settings.
- The Centers for Medicare & Medicaid Services (CMS) would also provide reimbursement for the use of SDM and ultimately further incentivize its use by reducing reimbursement levels for providers of elective surgery who fail to implement SDM programs.

HARMONIZE MEDICARE COPAYMENTS AND DEDUCTIBLES; PROVIDE A CAP ON COST SHARING: Medicare beneficiaries experience widely divergent copayments and deductibles. For example, the Part A deductible is more than $1,000 for each hospitalization while the Part B deductible is $135. Other services such as home health have no deductible or copayment.

This proposal would combine the myriad Part A and B copayments into a single $525 copay, implement a uniform 20% deductible and create an annual cap on total expenses of $5,250.

VARY ANNUAL PROVIDER PAYMENT UPDATES AND PENALIZE OVERUSE: Under this proposal, hospitals and other providers would receive different inflationary updates based on risk-adjusted patient outcome measures (mortality, safety, patient satisfaction) and cost. Providers delivering the higher quality care at lower costs would receive larger payment updates. This policy would also include a specific payment penalty for extreme outliers in terms of costs and quality.

CARE COORDINATION THROUGH ACCOUNTABLE CARE ORGANIZATIONS: Under this proposal, CMS would develop a voluntary program in which hospitals, multispecialty group practices and large primary care groups would establish organized delivery systems to care for chronically ill patients. By coordinating care and using best practices these groups would improve the quality of care, while also reducing the volume of care by eliminating the duplication of services.

Ultimately, this program would require providers to participate in an organized delivery system and demonstrate capacity to produce longitudinal management of chronic care as a condition of participation of Medicare for the treatment of the chronic ill.